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Contact: CMS Media Relations
(202) 690-6145 | CMS Media Inquiries

HHS Finalizes Rule to Strengthen Medicare, Improve Access to Affordable Prescription Drug Coverage, and Hold Private Insurance Companies Accountable to Delivering Quality Health Care for America's Seniors and People with Disabilities

Thanks to President Biden's new law to lower prescription drug costs, the final rule will also improve access to affordable prescription drug coverage for an estimated 300,000 low-income individuals

Today, the U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), is finalizing a rule to put people with Medicare first and put strong protections in place so that Medicare Advantage (MA) works for them. This final rule will strengthen Medicare Advantage and hold health insurance companies to higher standards for America's seniors and people with disabilities by cracking down on misleading marketing schemes by Medicare Advantage plans, Part D plans and their downstream entities; removing barriers to care created by complex coverage criteria and utilization management; and expanding access to behavioral health care. The new rule will also promote health equity, and implement a key provision of the Inflation Reduction Act—President Biden's new law to lower prescription drug costs—that will improve access to affordable prescription drug coverage for an estimated 300,000 low-income individuals.

The Biden-Harris Administration is committed to protecting and strengthening Medicare for the 65 million people with Medicare today and for future generations. In the past few months, the Department has taken a series of actions to ensure the Medicare Advantage program works for people with Medicare and that private insurance companies are held accountable for providing quality coverage and care:

- In February, CMS finalized a rule to start recovering improper payments made to Medicare Advantage plans through audits for the first time since 2007. Recovering these improper payments and returning this money to the Medicare Trust Funds will protect the fiscal sustainability of Medicare and allow the program to better serve seniors and people with disabilities, today and in the future.

- Last week, CMS finalized policies in the 2024 Medicare Advantage and Part D Rate Announcement to improve payment accuracy and ensure taxpayer dollars are appropriately safeguarded and well-spent.

"At HHS, we put seniors and people with disabilities first," said HHS Secretary Xavier Becerra. "That is exactly what we are doing today. In our latest effort to strengthen Medicare and hold insurance companies accountable, we are putting protections in place so that Medicare Advantage works for beneficiaries and they get the quality care they deserve. We will continue our efforts to deliver on the President's vision to strengthen this program for the millions of people with Medicare and for future generations to come."

"The Biden-Harris Administration has made exceptionally clear that one of its top priorities is protecting and strengthening Medicare," said CMS Administrator Chiquita Brooks-LaSure. "With this final rule, CMS is putting in place new safeguards that make it easier for people with Medicare to access the benefits and services they are entitled to, while also strengthening the Medicare Advantage and Part D programs."

"People with Medicare deserve to have access to accurate information when making coverage choices, and to be able to get the care they need without excessive burden or delays," said Dr. Meena Seshamani, CMS Deputy Administrator and Director of the Center for Medicare. "The commonsense policies in this rule further our goals to advance health equity, improve access to care, and drive high-quality, whole-person care."

Cracking Down on Misleading Marketing Schemes

The final rule includes changes to protect people exploring Medicare Advantage and Part D coverage from confusing and potentially misleading marketing practices. Ads will be prohibited if they do not mention a specific plan name, or if they use the Medicare name, CMS logo, and products or information issued by the Federal Government, including the Medicare card, in a misleading way. Further, the final rule strengthens accountability for plans to monitor agent and broker activity.

Removing Barriers to Care Created by Complex Prior Authorization and Utilization Management

CMS is also providing important protections regarding utilization management policies and coverage criteria that ensure that Medicare Advantage enrollees receive the same access to medically necessary care that they would receive in Traditional Medicare. The rule streamlines prior authorization requirements and reduces disruption for enrollees by requiring that a granted prior authorization approval remains valid for as long as medically necessary to avoid disruptions in care, requiring Medicare Advantage plans to annually review utilization management policies, and requiring denials of coverage based on medical necessity be reviewed by health care professionals with relevant expertise before a denial can be issued. These policies complement proposals in CMS' Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule (CMS-0057-P).

Expanding Access to Behavioral Health Care

CMS remains committed to emphasizing the critical role that access to behavioral health plays in whole person care. In line with CMS' Behavioral Health Strategy and the Administration's strategy to address the national mental health crisis, CMS is strengthening behavioral health network adequacy in Medicare Advantage by adding clinical psychologists and licensed clinical

social workers to the list of evaluated specialties. CMS is also finalizing wait time standards for behavioral health and primary care services and more specific notice requirements from plans to patients when these providers are dropped from their networks. In addition, CMS is requiring most types of Medicare Advantage plans to include behavioral health services in care coordination programs, ensuring that behavioral health care is a core part of person-centered care planning.

Promoting More Equitable Care

Additionally, CMS is advancing health equity and driving quality in health coverage by establishing a health equity index in the Star Ratings program that will reward Medicare Advantage and Medicare Part D plans that provide excellent care for underserved populations. Plans will also be required to provide culturally competent care to an expanded list of populations and to improve equitable access to care for those with limited English proficiency, through newly expanded requirements for providing materials in alternate formats and languages. The final rule balances patient experience/complaints measures, access measures, and health outcomes measures in the Star Ratings program to more effectively focus both on patient-centric care and on improving clinical outcomes.

Implementing President Biden's New Prescription Drug Law

The final rule also implements a key provision of the Inflation Reduction Act that improves access to affordable prescription drug coverage for approximately 300,000 low-income individuals. As outlined in President Biden's new prescription drug law, CMS is expanding eligibility for the full low-income subsidy benefit (also known as "Extra Help") to individuals with incomes up to 150% of the federal poverty level who meet eligibility criteria. Beginning January 1, 2024, this change will provide the full low-income subsidy to those who would currently qualify for the partial low-income subsidy. As a result of this change, eligible enrollees will have no deductible, no premiums (if enrolled in a "benchmark" plan), and fixed, lowered copayments for certain medications under Medicare Part D.

View a fact sheet on the final rule.

The final rule can be accessed from the Federal Register at:
https://www.federalregister.gov/public-inspection/current

Medicare Advantage Value-Based Insurance Design Model Extension

Additionally, today CMS is also releasing more information about the extension of the Center for Medicare and Medicaid Innovation's Medicare Advantage Value-Based Insurance Design (VBID) Model from 2025 through 2030. This extension will introduce changes intended to more fully address the health-related social needs of patients, advance health equity, and improve care coordination for patients with serious illness. View the fact sheet, and more information, on the model webpage.

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